TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS BONE & JOINT CENTER

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-14-2959-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
May 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The Requestor did not include a position summary with the DWC060 request.

Amount in Dispute: $1,068.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has paid the majority of the services pursuant to the fee guidelines. No additional reimbursement is owed for any date of service in which payment has been issued. The only medical treatment in which payment was not issued was CPTR Code 97002 billed for date of service 1/15/14. On this date, an orthopedic doctor billed for a physical therapy evaluation when the physical therapist completed the evaluation. Pursuant to DWC Rule 133.20 (e) (2), a medical bill must be submitted in the name of the licensed provider who performed the treatment. In conclusion, requestor is not owed any additional reimbursement for the dates of service at issue in this matter."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2014 through February 12, 2014	97530 x 2, 97110 x 2, 73030, 99080-73 x 2	$855.00	$0.00
January 15, 2014	97002	$213.00	$65.68
TOTAL		$1,068.00	$65.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.20 sets out the procedure for Medical Bill Submission by Health Care Provider.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Note: Per Rule 133.20 (3)(2) a medical bill must be submitted in the name of the licensed HCP that provided the healthcare or that provided direct supervision of an unlicensed individual who provided the health care. Dodson PT, Physical therapy reevaluation cod...
   - 8 – Procedure Code Inconsistent with Provider Type.
   - B20 – Srvc partially/fully furnished by another provider.
   - W3 –Appeal/reconsideration.

Issues

1. Did the insurance carrier issue payment to the requestor for disputed dates of service January 10, 2014, January 13, 2014 January 15, 2014 and February 12, 2014?
2. Did the requestor bill for services in accordance with 28 Texas Administrative Code §133.20 for CPT Code 97002?
3. Is the requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement in the amount of $855.00, for CPT Codes 97530 x 2, 97110 x 2, 73030, 99080-73 x 2 rendered on January 10, 2014 through February 12, 2014. Review of the insurance carrier's response, supports that the insurance carrier issued payment to the requestor for the disputed CPT Codes identified above. Communication with the requestor contact, Tammy Plant on September 5, 2014, confirmed that payment was received for all disputed dates of service with the exception of CPT Code 97002 rendered on January 15, 2014. The Requestor continues to pursue dispute resolution for this service, as a result, the Division will issue a finding and decision for CPT Code 97002 rendered on January 15 2014.

2. The requestor seeks resolution for CPT Code 97002 rendered on January 15, 2014. The insurance carrier denied the disputed service with denial reason codes "Note: Per Rule 133.20 (3)(2) a medical bill must be submitted in the name of the licensed HCP that provided the healthcare or that provided direct supervision of an unlicensed individual who provided the health care Dodson PT, Physical therapy reevaluation cod; 8 – Procedure Code Inconsistent with Provider Type; and B20 – Srvc partially/fully furnished by another provider."

   Per 28 Texas Administrative Code §133.20 states in pertinent part, "(d) The health care provider that provided the health care shall submit its own bill, unless... (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill..."

   Review of the documented titled *Re-Evaluation* and the CMS-1500, box 31 and 24 J, supports that the medical bill was submitted in the name of the licensed HCP that provided the healthcare. As a result, the requestor is entitled to reimbursement for CPT Code 97002 rendered on January 15, 2014.

3. 28 Texas Administrative Code §134.203 states, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   28 Texas Administrative Code §134.203 states, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The Requestor seeks reimbursement in the amount of $213.00. The MAR reimbursement for CPT Code 97002 is $65.68, as a result the requestor is entitled to the MAR amount of $65.68. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $65.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $65.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.